New Vision Counseling Center, LLC

"Offering a New Vision to Meet Your Life's Destiny"

Client Information, Consent, and Financial Agreement

A. IDENTIFICATION

Client Name: _____ Sex: _____ Date of Birth: _____/_____/_____Age: _____
Employer/School: _____ SS #: _____-_____-_____
Home Address: _____
City: _____ State: _____ Zip: _____
Phone~ Home: (_____) _____ Work: (_____) _____ Cell: (_____) _____
Email: _____
Which numbers/email listed above may we leave a message on? _____

If client is a minor: **Names of Parent(s)/Guardian(s): _____**

Emergency Contact Name and Number:

B. RESPONSIBLE PARTY INFORMATION: ☐ Check if the same as client (skip this section)

Guardian Name: _____ Sex: _____ Date of Birth: _____/_____/_____
Relation to Patient: _____ SS #: _____-_____-_____ Employer: _____
☐ Same address as client: ☐ Different address than the client (Please complete address below)
Home Address: _____
City: _____ State: _____ Zip: _____
☐ Same home phone as client ☐ Different home phone: Home: (_____) _____
Other Phones: Work: (_____) _____ Cell: (_____) _____ Email: _____

C. INSURANCE INFORMATION ~Please provide insurance card~ Skip if self-pay

Policyholder's Name _____ Policyholder's SSN: _____-_____-_____
Date of Birth _____/_____/_____ Primary Insurance Co. Name _____
Insurance Company's Customer Service Phone # _____ Insurance ID #_ _____
Policyholder's Employer: _____ Group #_____
Co-pay $ _____ Deductible? ☐ Yes ☐ No Amount $_____
Authorization Required? ☐ Yes ☐ No Authorization # _____
Number of Sessions Authorized _____ Maximum Number of Sessions Allowed Per Year _____

Is the patient covered under a secondary insurance policy? ☐ Yes ☐ No

I, _____ (client or legal guardian) authorize Kristy Christopher, LPC/ New Vision Counseling Center, LLC, or any holder of medical information about me to release to my insurance company or its representative, any information needed concerning the examination or treatment rendered to me that is necessary to process the insurance claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits to be paid directly to Kristy Christopher, LPC/ New Vision Counseling Center, LLC in such amount as my benefits allow. This authorization is effective until terminated in writing by the client or their guardian.

_____ _____
Client or Legal Guardian Date

D. Medical History

*Please list all Physician Names& Numbers:

_____

_____

Medication: _____ Dosage: _____ Reason: _____ Date Started: _____
Medication: _____ Dosage: _____ Reason: _____ Date Started: _____

Allergies: _____
List any serious accidents, illnesses, operations or hospitalizations and what year._____
_____

E. Family of origin

Relative	Name	Age	Illness	Education	Occupation	Quality of Relationship
Father						
Mother						
Step-Father						
Step-Mother						
Brother (s)						
Sister (s)						

F. Marital History

Spouse's Name: _____ Years Married: _____
Previous Married? ☐ Yes ☐ No Reason for Divorce: _____

G. Symptoms

Physical Health/Symptoms
☐ Headache ☐ Vomiting ☐ Diarrhea ☐ Dizziness ☐ Chest Pain ☐ Shortness of Breath

Function/Activity
☐ Fatigue ☐ Little/No Sleep ☐ Weight Loss ☐ Weight Gain ☐ Academic/Work Inhibition ☐ Loss of Interest/Pleasure ☐ Excessive Worry ☐ Self Injury ☐ Substance Use/Abuse (Alcohol ☐ Drugs ☐ Other ☐)

Emotional Symptoms
☐ Hopelessness ☐ Panic/Anxiety ☐ Anger ☐ Tearful ☐ Suicidal Thoughts ☐ Indecisive ☐ Fearful ☐ Other

The three biggest problems in my life right now are:

1._____ 2. _____ 3. _____

RELEASE OF INFORMATION

I, _____, do hereby authorize _____ or any related representative at New Vision Counseling Center, LLC to

☐ release ☐ receive ☐ exchange

information concerning _____ (Name of Client, DOB)

☐ to ☐ from ☐ with _____

I understand that such disclosure will be made for the following purposes:

☐ Treatment Progress ☐ Psychiatric Evaluation ☐ Child Custody / Visitation
☐ Treatment Planning ☐ Social History ☐ Competency to stand trial
☐ Medical Treatment ☐ Treatment Summary ☐ Other _____
☐ Reimbursement for Treatment ☐ Diagnosis

I understand that unless otherwise limited by state or federal regulations, and except to the extent that action has been taken which was based on my consent, I may withdraw this consent at any time by giving written notice to Kristy Christopher, LPC

If no prior notice of revocation is received, this consent will expire automatically two (2) years after the date indicated thereon.

I understand that information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule.

I have read, or had read to me, the above, and understand the contents.

_____ I authorize this information to be faxed to the party indicated above, and
Initial understand the limits of confidentiality which doing so creates.

_____ I have received and read the ROI, however at this time, I do not have anyone I wish to release
Initial information to. I am aware that I can make additions/changes as necessary and at anytime by completing this form.

_____ _____
Signature of client, parent, or legal guardian Date

Training of Professionals:

New Vision Counseling Center, LLC is committed to providing excellent mental health services to the community. Because of this, from time to time we will engage in training interns and/or newly licensed professionals. This can result in more affordable fees to those who are in need as well as the professional growth of those we train. In order to provide this opportunity, sometimes trainees are required to sit in on sessions, record/take notes of sessions or discuss the case with a fully licensed mental health supervisor. During this, none of your identifying information is ever disclosed and your confidentiality will remain of upmost regard. If you wish to participate in this training opportunity, please sign. You can opt out at any time simply through verbal or written communication.

_____

Signature and date

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THE PROFESSIONAL SERVICES AGREEMENT AND AGREE TO ITS TERMS. YOUR SIGNATURE ALSO SERVES AS AN ACKNOWLEDGEMENT THAT YOU HAVE RECEIVED THE HIPAA NOTICE FORM DESCRIBED ON THE FOLLOWING PAGES.

PATIENT (or PARENTS/GUARDIANS, IF PATIENT IS A MINOR)

_____ _____

Signature of Patient or Parent(s)/Guardian(s) **Date**

_____ _____

Name of Patient or Parent(s)/Guardian(s) ***(Please print)*** **Relationship(s) to Patient**

OTHER ADULT PARTY/PARTIES INVOLVED IN TREATMENT ☐ **NOT APPLICABLE**

_____ _____

Signature of Secondary Party/Parties **Date**

_____ _____

Name of Secondary Party/Parties ***(Please print)*** **Relationship(s) to Patient**

_____ _____

Signature of Therapist **Date**

_____

Name of Therapist

INFORMATION, AUTHORIZATION, & CONSENT TO TELEMENTAL HEALTH

Thank you so much for choosing the services that we provide. This document is designed to inform you about what you can expect from us regarding confidentiality, emergencies, and several other details regarding your treatment as it pertains to TeleMental Health. TeleMental Health is defined as follows:

> "TeleMental Health means the mode of delivering services via technology-assisted media, such as but not limited to, a telephone, video, internet, a smartphone, tablet, PC desktop system or other electronic means using appropriate encryption technology for electronic health information. TeleMental Health facilitates client self-management and support for clients and includes synchronous interactions and asynchronous store and forward transfers." (Georgia Code 135-11-.01)

TeleMental Health is a relatively new concept despite the fact that many therapists have been using technology-assisted media for years. Breaches of confidentiality over the past decade have made it evident that Personal Health Information (PHI) as it relates to technology needs an extra level of protection. Additionally, there are several other factors that need to be considered regarding the delivery of TeleMental Health services in order to provide you with the highest level of care. Therefore, our therapists have completed specialized training in TeleMental Health. We have also developed several policies and protective measures to assure your PHI remains confidential. These are discussed below.

The Different Forms of Technology-Assisted Media Explained

Telephone via Landline:
It is important for you to know that even landline telephones may not be completely secure and confidential. There is a possibility that someone could overhear or even intercept your conversations with special technology. Individuals who have access to your telephone or your telephone bill may be able to determine who you have talked to, who initiated that call, and how long the conversation lasted. If you have a landline and you provided us with that phone number, we may contact you on this line from our own landline in our office or from a cell phone, typically only for purposes of setting up an appointment if needed. If this is not an acceptable way to contact you, please let your therapist know. Telephone conversations (other than just setting up appointments) are billed at your therapist's hourly rate.

Cell phones:
In addition to landlines, cell phones may not be completely secure or confidential. There is also a possibility that someone could overhear or intercept your conversations. Be aware that individuals who have access to your cell phone or your cell phone bill may be able to see who you have talked to, who initiated that call, how long the conversation was, and where each party was located when that call occurred. However, we realize that most people have and utilize a cell phone. We may also use a cell phone to contact you, typically only for purposes of setting up an appointment if needed. Additionally, your therapist may keep your phone number in his/her cell phone, but it will be listed by your initials only and his/her phone is password protected. If this is a problem, please let your therapist know, and you he/she will be glad to discuss other options. Telephone conversations (other than just setting up appointments) are billed at your therapist's hourly rate.

OUR POLICY REGARDING TEXT MESSAGING:

Text Messaging:
Text messaging is not a secure means of communication and may compromise your confidentiality. Furthermore, sometimes people misinterpret the meaning of a text message and/or the emotion behind it. Therefore, **we do not utilize texting in our therapy practice, and your therapist will not respond to a text**

Please initial that you have read this page:

message for your protection. If you happen to send your therapist a text message by accident, you need to know that she or he is required to keep a copy or summary of all texts as part of your clinical record that address anything related to therapy. Furthermore, we will not contact you from personal cellular devices and if so

OUR POLICY REGARDING EMAIL USAGE

Email:
Email is not a secure means of communication and may compromise your confidentiality. However, we realize that many people prefer to email because it is a quick way to convey information. **Nonetheless, please know that it is our policy to utilize this means of communication strictly for appointment confirmations.** Please do not bring up any therapeutic content via email to prevent compromising your confidentiality. You also need to know that we are required to keep a copy or summary of all emails as part of your clinical record that address anything related to therapy. **Furthermore, we will not respond to any communications sent via email, but you may feel free to use our HIPAA compliant Patient Portal to have limited communication with your therapist or to send useful clinical information such as medical releases or psychological reports. We will not respond to communications that are therapeutic in nature.**

We also strongly suggest that you only communicate through a device that you know is safe and technologically secure (e.g., has a firewall, anti-virus software installed, is password protected, not accessing the internet through a public wireless network, etc.). If you are in a crisis, please do not communicate this to us via email because we may not see it in a timely matter. Instead, please see below under "Emergency Procedures."

Social Media - Facebook, Twitter, LinkedIn, Instagram, Pinterest, Etc:
It is our policy ***not*** to accept "friend" or "connection" requests from any current or former client on any of our therapist's **personal** social networking sites such as Facebook, Twitter, Instagram, Pinterest, etc. because it may compromise your confidentiality and blur the boundaries of your relationship. However, New Vision Counseling Center, LLC has a **professional** Facebook page, **professional** Twitter page, and **professional** Instagram page. You are welcome to "follow" us on any of these **professional** pages where we post counseling information/therapeutic content. However, please do so only if you are comfortable with the general public being aware of the fact that your name is attached to New Vision Counseling Center, LLC. Please refrain from making contact with us using social media messaging systems such as Facebook Messenger or Twitter. These methods have insufficient security, and we do not watch them closely. We would not want to miss an important message from you.

Blogs:
We may post counseling information/therapeutic content on our professional blog. If you have an interest in following our blog, please feel free to do so. However, please be mindful that the general public may see that you're following New Vision Counseling Center's blog. Once again, maintaining your confidentiality is a priority.

Video Conferencing (VC):
Video Conferencing may be an option for your therapist to conduct remote sessions with you over the internet where you may speak to one another as well as see one another on a screen. We currently use Doxy.me or Zoom Platforms only. This VC platform is encrypted to the federal standard, HIPAA compatible, and has signed a HIPAA Business Associate Agreement (BAA). The BAA means that Doxy.me or Zoom is willing to attest to HIPAA compliance and assumes responsibility for keeping your VC interaction secure and confidential. If you and your therapist choose to utilize this technology, your therapist will give you detailed directions regarding how to log-in securely. We also ask that you please sign on to the platform at least five minutes prior to your session time to ensure you and your therapist get started promptly. Additionally, you are responsible for initiating the connection with your therapist at the time of your appointment. **Not doing so could result in being assessed the missed visit fee**. Additionally, any fees must be paid prior to beginning the VC. We strongly suggest that you only communicate through a computer or device that you know is safe (e.g., has a firewall, anti-virus software installed, is password protected, not accessing the internet through a public wireless network, etc.).

Please initial that you have read this page:

Website Portal:
We have a client portal that is accessible through our website at www.newvisioncounselingcenter.com, which is powered by EHRYourWay. EHRYourWay ensures this portal is encrypted to the federal standard, HIPAA compatible, and has agreed to sign a HIPAA Business Associate Agreement (BAA). The BAA means that EHRYourWay is willing to attest to HIPAA compliance and assumes responsibility for keeping our interactions secure and your PHI confidential. If we choose to utilize this technology, we will give you detailed directions regarding how to log-in securely when you schedule your first appointment. Login credentials are emailed to you from noreply@ehryourway.com and not from our office. If you do not receive an email, please be sure to check your spam/junk folder. We also strongly suggest that you only communicate through a device that you know is safe (e.g., has a firewall, anti-virus software installed, is password protected, not accessing the internet through a public wireless network, etc.).

Recommendations to Websites or Applications (Apps):
During the course of our treatment, your therapist may recommend that you visit certain websites for pertinent information or self-help. She or he may also recommend certain apps that could be of assistance to you and enhance your treatment. Please be aware that websites and apps may have tracking devices that allow automated software or other entities to know that you've visited these sites or applications. They may even utilize your information to attempt to sell you other products. Additionally, anyone who has access to the device you used to visit these sites and/or apps, may be able to see that you have been to these sites by viewing the history on your device. Therefore, it is your responsibility to decide if you would like this information as adjunct to your treatment or if you prefer that your therapist does not make these recommendations. Please let your therapist know by checking (or not checking) the appropriate box at the end of this document.

Electronic Record Storage:
Your communications with us will become part of a clinical record of treatment, and it is referred to as Protected Health Information (PHI). Your PHI will be stored electronically with EHRYourWay, a secure storage company who has signed a HIPAA Business Associate Agreement (BAA). The BAA ensures that they will maintain the confidentiality of your PHI in a HIPAA compatible secure format using point-to-point, federally approved encryption**.** Additionally, your PHI will be kept on our password protected computer in an encrypted file format.

Electronic Transfer of PHI for Billing Purposes:
If your therapist is credentialed with and a provider for your insurance carrier, please know that we utilize a billing service who has access to your PHI. Your PHI will be securely transferred electronically to EHRYourWay and OfficeAlly. This billing company has signed a HIPAA Business Associate Agreement (BAA). The BAA ensures that they will maintain the confidentiality of your PHI in a HIPAA compatible secure format using point-to-point, federally approved encryption. Additionally, if your insurance provider is billed, you will generally receive correspondence from your insurance company, our billing company, or both.

Electronic Transfer of PHI for Certain Credit Card Transactions:
We utilize Bank of America as the company that processes your credit card information. This company may send the credit card-holder a text or an email receipt indicating that you used that credit card at our facility, the date you used it, and the amount that was charged. This notification is usually set up two different ways - either upon your request at the time the card is run or automatically. Please know that it is your responsibility to know if you or the credit card-holder has the automatic receipt notification set up in order to maintain your confidentiality if you do not want a receipt sent via text or email. Additionally, please be aware that the transaction will also appear on your credit-card bill. The name on the charge will appear as New Vision Counseling Ctr, LLC.

Your Responsibilities for Confidentiality & TeleMental Health

Please communicate only through devices that you know are secure as described above. It is also your responsibility to choose a secure location to interact with technology-assisted media and to be aware that family, friends,

Please initial that you have read this page:

employers, co-workers, strangers, and hackers could either overhear your communications or have access to the technology that you are interacting with. Additionally, you agree not to record any TeleMental Health sessions.

Communication Response Time

I'm required to make sure that you're aware that I'm located in the Southeast and we abide by Eastern Standard Time. Our practice is considered to be an outpatient facility, and we are set up to accommodate individuals who are reasonably safe and resourceful. **We are not an emergency receiving facility; therefore, we do not carry beepers nor are we available at all times**. If at any time this does not feel like sufficient support, please inform your therapist, and he or she can discuss additional resources or transfer your case to a therapist or clinic with 24-hour availability. We will return phone calls within 24-48 business hours. However, we may not respond to calls or patient portal communications on weekends (if your therapist does not see clients on weekends) or holidays. If you are having a mental health emergency and need immediate assistance, please follow the instructions below.

In Case of an Emergency

If you have a mental health emergency, we encourage you not to wait for communication back from your therapist, but do one or more of the following:

- Call Behavioral Health Link/GCAL: 800-715-4225 or other 24 hour crisis hotline in your area
- Call Ridgeview Institute at 770.434.4567 or local hospital
- Call Peachford Hospital at 770.454.5589 or local hospital
- Call Lifeline at (800) 273-8255 (National Crisis Line)
- Call 911.
- Go to the emergency room of your choice.

Emergency Procedures Specific to TeleMental Health Services

There are additional procedures that we need to have in place specific to TeleMental Health services. These are for your safety in case of an emergency and are as follows:

- You understand that if you are having suicidal or homicidal thoughts, experiencing psychotic symptoms, or in a crisis that we cannot solve remotely, we may determine that you need a higher level of care and TeleMental Health services are not appropriate.
- We require an Emergency Contact Person (ECP) who we may contact on your behalf in a life-threatening emergency only. Please write this person's name and contact information below. Either you or we will verify that your ECP is willing and able to go to your location in the event of an emergency. Additionally, if either you, your ECP, or we determine necessary, the ECP agrees take you to a hospital. Your signature at the end of this document indicates that you understand we will only contact this individual in the extreme circumstances stated above. Please list your ECP here:
  Name: _____ Phone: _____
- You agree to inform your therapist of the address where you are at the beginning of every TeleMental Health session.
- You agree to inform your therapist of the nearest mental health hospital to your primary location that you prefer to go to in the event of a mental health emergency (usually located where you will typically be during a TeleMental Health session). Please list this hospital and contact number here:
  Hospital: _____ Phone: _____

In Case of Technology Failure

During a TeleMental Health session, you and your therapist could encounter a technological failure. The most reliable backup plan is to contact one another via telephone. Please make sure you have a phone with you, and your therapist has that phone number. If you and your therapist get disconnected from a video conferencing or chat session, end and restart the session. If you are unable to reconnect within five minutes, please call your therapist.

Please initial that you have read this page:

If you and your therapist are on a phone session and you get disconnected, please call your therapist back or contact her or him to schedule another session. If the issue is due to *your therapist's* phone service, and the two of you are not able to reconnect, she/he will not charge you for that session.

Structure and Cost of Sessions

At New Vision Counseling Center, we offer primarily face-to-face counseling. However, based on your ability to make in-person sessions, your therapist may provide phone or video conferencing if your treatment needs determine that TeleMental Health services are appropriate for you. If appropriate, you may engage in either face-to-face sessions, TeleMental Health, or both. You and your therapist will discuss what is best for you.

The structure and cost of TeleMental Health sessions **are exactly the same** as face-to-face sessions described in our general "Professional Services agreement and Financial Agreement" forms. **We require a credit card ahead of time for TeleMental Health therapy for ease of billing. Please sign the Financial Agreement Form, which was provided to you separately and indicates that we may charge your card without you being physically present**. Your credit card will be charged at the beginning of each TeleMental Health interaction. **This includes any therapeutic interaction other than setting up appointments.** Visa, MasterCard, or American Express are acceptable for payment, and we will provide you with a receipt of payment and the services that we provided.

The receipt of payment & services completed may also be used as a statement for insurance if applicable to you. Insurance companies have many rules and requirements specific to certain benefit plans. At the present time, some do not cover TeleMental Health services. **Unless otherwise negotiated, it is your responsibility to find out your insurance company's policies and to file for insurance reimbursement for TeleMental Health services.** As stated above, we will be glad to provide you with a statement for your insurance company and to assist you with any questions you may have in this area. You are also responsible for the cost of any technology you may use at your own location. This includes your computer, cell phone, tablet, internet or phone charges, software, headset, etc.

Cancellation Policy

In the event that you are unable to keep either a face-to-face appointment or a TeleMental Health appointment, you must notify your therapist at least 24 hours in advance. If such advance notice is not received, you will be financially responsible for the session you missed. Please note that insurance companies do not reimburse for missed sessions.

Limitations of TeleMental Health Therapy Services

TeleMental Health services should not be viewed as a complete substitute for therapy conducted in our office, unless there are extreme circumstances that prevent you from attending therapy in person. It is an alternative form of therapy or adjunct therapy, and it involves limitations. Primarily, there is a risk of misunderstanding one another when communication lacks visual or auditory cues. For example, if video quality is lacking for some reason, your therapist might not see a tear in your eye. Or, if audio quality is lacking, he or she might not hear the crack in your voice that he or she could have easily picked up if you were in our office. There may also be a disruption to the service (e.g., phone gets cut off or video drops). This can be frustrating and interrupt the normal flow of personal interaction. Please know that we have the utmost respect and positive regard for you and your wellbeing. We would never do or say anything intentionally to hurt you in any way, and we strongly encourage you to let your therapist know if something she or he has done or said upset you. We invite you to keep the communication with your therapist open at all times to reduce any possible harm.

Face-to Face Requirement

If you and your therapist agree that TeleMental Health services are the **primary** way that you and your therapist choose to conduct sessions, **we *may* require one to two face-to-face meetings at the onset of treatment.** We

Please initial that you have read this page:

prefer for this initial meeting to take place in our office. If that is not possible, we can utilize video conferencing as described above. During this initial session, your therapist will require you to show a valid picture ID and another form of identity verification such a credit card in your name. **At this time, you will also choose a password, phrase, or number which you will use to identify yourself in all future sessions. This procedure prevents another person from posing as you.**

Consent to TeleMental Health Services

Please check the TeleMental Health services you are authorizing your therapist to utilize for your treatment or administrative purposes. You and your therapist will ultimately determine which modes of communication are best for you. However, you may withdraw your authorization to use any of these services at any time during the course of your treatment just by notifying us in writing. If you do not see an item discussed previously in this document listed for your authorization below, this is because it is built-in to our practice, and we will be utilizing that technology unless otherwise negotiated by you.

- ☐ Email (for appointment reminders only)
- ☐ Video Conferencing
- ☐ Website Portal
- ☐ Recommendations to Websites or Apps

In summary, technology is constantly changing, and there are implications to all of the above that we may not realize at this time. Feel free to ask questions, and please know that we are open to any feelings or thoughts you have about these and other modalities of communication and treatment.

Please print, date, and sign your name below indicating that you have read and understand the contents of this form, you agree to these policies, and you are authorizing us to utilize the TeleMental Health methods discussed.

_____ _____

Client Name (Please Print) **Date**

_____

Client Signature

If Applicable:

_____ _____

Parent's or Legal Guardian's Name (Please Print) **Date**

_____

Parent's or Legal Guardian's Signature

Your therapist's signature below indicates that he or she has discussed this form with you and has answered any questions you have regarding this information.

_____ _____

Therapist's Signature **Date**

Please initial that you have read this page:

NEW VISION COUNSELING CENTER, LLC
FINANCIAL AGREEMENT AND PROMISE TO PAY ACCOUNT

For in and consideration of services rendered and to be rendered to _____ (client name), I will promise to pay New Vision Counseling Center, LLC (NVCC). I understand the total charges are due when services are rendered. I agree to make available any and all insurance information to NVCC and/or billing personnel. I understand that NVCC bills from One hundred and twenty five dollars to one hundred and seventy dollars ($125-$170) for sessions lasting 45-60 minutes, based upon therapist and their licensure. I agree to provide insurance claim forms of any insurance company and/or will complete the HCFA 1500 form. I agree to assign any and all benefits to NVCC and sign in the designated areas on the insurance claim form. I agree to pay the entire deductible amount, as well as any co-payment amount due.

I understand that I am financially responsible for missed appointments, in which I do not give a 24- hour notice and that my credit card will be charged if I do not give the 24 hour notice. **The fee for a missed visit (in which less than 24- hour notice is given, including weekends) is $75.00.**

In addition, if my insurance company fails to pay for each date of service with in four weeks, I will be billed for the date of service. I will be provided with a super bill so you can be reimbursed by my insurance company. In this process, if payment is received after the four week date of service; I will be reimbursed by NVCC. By signing this agreement I completely understand that it is my responsibility to handle all insurance matters, including getting authorization and untimely payment by my insurance company (more than 4 weeks after date of service). I understand that NVCC will file each date of service one time and any rejection payment from my insurance company will be taken care of by me.

I understand that I am financially responsible for all charges not covered or denied by my insurance company. I understand that if I should receive payment from the insurance company by mistake, which payment was/should be assigned to NVCC, I will sign this payment over to NVCC and NVCC has the right to seek legal action to receive payment for this agreement, relative to payment fees, NVCC shall be entitled to reasonable attorney fees and cost of collection.

I further understand that no records (written or verbal) will be released to me or on my behalf if I have an outstanding balance due to NVCC.

NVCC does not accept checks. Please provide us with your credit card information. The card will ONLY be billed for tele-mental health services, if less than 24 hour notice is given, or on accounts that are 60 days past due:

Type of card: _____ (We only accept Visa, MC, and Discover)
Name as it appears on card: _____
Card #: _____
Exp: _____

By signing below, I am agreeing to the terms and conditions of this financial contract. I understand that if I do not provide a card number, I may be subject to pay any outstanding balance before scheduling an appointment.

_____

_____
Signature **Date**

FINANCIAL AGREEMENT AND PROMISE TO PAY ACCOUNT
Court Attendance, On-Call, and Communication with Attorneys/Other Professionals

For in and in consideration of court attendance, I _____ (**client name or guardian if minor child**) promise to pay New Vision Counseling Center, LLC (NVCC). I understand that New Vision Counseling Center, LLC bills at the rate of $200.00 per hour for court attendance. I agree to provide New Vision Counseling Center, LLC with my credit card information. I understand that the hourly rate begins when the therapist leaves their location. **I understand that a fee for two hours will be paid prior to court attendance, ($400.00) and is non-refundable if less time is needed**. If the court attendance exceeds two hours, I understand that my credit card will be billed for the remaining time. In addition, I understand that I am not paying for the therapist's testimony; I am paying for their time. Therefore, the fees are expected to be paid regardless of whether the therapist testifies or not.

On call policy:
I understand that if I request my therapist to be on-call for court attendance, New Vision Counseling Center, LLC bills at the rate of $60.00 per hour for on-call. I agree to provide New Vision Counseling Center, LLC with my credit card information in order for the payment to be charged. I understand that the hours I am requesting the therapist to be on call will immediately be charged to my credit card, and is non-refundable.

Communication with Attorneys/Other professionals/Report writing:
I understand that New Vision Counseling Center, LLC bills at the rate of $100.00 per hour for any type of communication with attorneys/other professionals/report writing (phone calls, letter writing, email, consultation, etc). I understand that I will need to provide my credit card information prior to any communication my therapist will have with my attorney/outside professional. I understand that a minimum of 30 minute increments will be billed to my credit card and is non-refundable.

Records Request
For ***each separate*** request, New Vision Counseling Center, LLC bills a flat rate of $25 for records to be copied and faxed/given to the client. If records need to be mailed, an additional fee of $10 is assessed to cover certified mail and postage. After payment is received and processed, please allow up to 7 business days for copies to be provided and/or mailed. **I also understand that no disability paperwork, work leave of absence, FMLA, etc will be completed before the third (3rd) session.** I further understand that no records (written or verbal) will be released to me or on my behalf if I have an outstanding balance due to NVCC. I understand that I am financially responsible for all charges and NVCC as the right to seek legal action to receive payment for this agreement, relative to payment fees, NVCC shall be entitled to reasonable attorney fees and cost of collection.

NVCC does not accept checks. Please Provide Credit Card Information:
Name as it appears of Card: _____

Type of Card: _____ (We only accept Visa, MC, and Discover)

Number on Card:

Expiration Date on Card: _____

By signing below, I am agreeing to the terms and conditions of this financial contract. I understand that if I do not provide a card number, I may be subject to pay any outstanding balance before scheduling an appointment.

Signature **Date**

Please read the Professional Services Agreement below then click the Submit Form button. Thank you

Submit Form

PROFESSIONAL SERVICES AGREEMENT

Welcome to my practice, New Vision Counseling Center, LLC. This document (the Agreement) contains important information about my professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a new federal law that provides new privacy protections and new patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. HIPAA requires that I provide you with a Notice of Privacy Practices (the Notice) for use and disclosure of PHI for treatment, payment and health care operations. The Notice, which is attached to this Agreement, explains HIPAA and its application to your personal health information in greater detail. The law requires that I obtain your signature acknowledging that I have provided you with this information. Although these documents are long and sometimes complex, it is very important that you read them carefully before our next session. We can discuss any questions you have about the procedures at that time. When you sign this document, it will also represent an agreement between us. You may revoke this Agreement in writing at any time. That revocation will be binding on me unless I have taken action in reliance on it; if there are obligations imposed on me by your health insurer in order to process or substantiate claims made under your policy; or if you have not satisfied any financial obligations you have incurred.

Psychological Services

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the psychologist and patient, and the particular problems you or your child are experiencing. There are many different methods I may use to deal with the problems that you hope to address. Psychotherapy is not like a medical doctor visit. Instead, it calls for a very active effort on your part. In order for the therapy to be most successful, you or your child will have to work on things we talk about both during our sessions and at home. Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has also been shown to have many benefits. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. Before we begin working together, it is important to understand that I cannot guarantee that you or your child will benefit from therapy. No therapist can make such a guarantee because each client responds differently to this experience. Our first few sessions will involve an evaluation of needs. By the end of the evaluation, I will be able to offer you some first impressions of what our work will include and a treatment plan to follow, if you decide to continue with therapy. You should evaluate this information along with your own opinions of whether you feel comfortable working with me. Therapy involves a large commitment of time, money, and energy, so you should be very careful about the therapist you select. If you have questions about my procedures, we should discuss them whenever they arise. If your doubts persist, I will be happy to help you obtain an appropriate consultation with another mental health professional.

Sessions

I normally conduct an evaluation that will last from 1to 2 sessions. During this time, we can both decide if I am the best person to provide the services you or your child needs in order to meet your treatment goals. If psychotherapy is begun, I will usually schedule one 45-50 minute session (one appointment hour of 45-50 minutes duration) per week at a time we agree on, although some sessions may be longer or more frequent. Once an appointment hour is scheduled, you will be expected to pay for it unless you provide 24 hours notice of cancellation. **Failure to cancel within 24 hours will result in you being charged the missed visit amount.**

Contacting Me

Due to my work schedule, I am often not immediately available by telephone. While I am usually in my office regular hours, I probably will not answer the phone when I am with a client. When I am unavailable, my telephone is answered by voice mail that I monitor frequently. I will make every effort to return your call as soon as possible. If you are difficult to reach, please inform me of some times when you will be available. If you have an emergency, leave a message for me and I will then attempt to call you as soon as possible, usually within the hour. If you are unable to reach me and feel that you cannot wait for me to return your call, contact your family physician, call 911, or call the nearest emergency room. If I will be unavailable for an extended time, I will always inform you and make appropriate arraignments with you. Contact is not made via email.

Confidentiality

The law protects the privacy of all communications between a patient and a therapist. In most situations, I can only release information to others about your treatment (or your child's treatment) if you sign a written authorization form that meets certain legal requirements imposed by HIPAA. There are other situations that require only that you provide written, advance consent. Your signature on this current agreement provides consent for those activities, as follows:

- I may occasionally find it helpful to consult other health and mental health professionals about a case. During a consultation, I make every effort to avoid revealing the identity of my patient. The other professionals are also legally bound to keep the information confidential. If you do not object, I will not tell you about these consultations unless I feel it is important for our work together. I will note all consultations in your Clinical Record (which is called PHI in my notice of psychologists policies and practices to protect the privacy of your health information)
- You should be aware that I may employ administrative staff. In most cases, I need to share protected information with these individuals for administrative purposes, such as scheduling, billing and communication with insurance companies. All staff members have been given training about protecting your privacy and have agreed not to release any information outside of the practice without the permission of a professional staff member.
- Disclosures required by health insurers or to collect overdue fees are discussed elsewhere in this agreement.
- If a patient threatens to harm himself / herself, I may be obligated to seek hospitalization for him/her and/or to contact family members, or others who can help provide protection.

There are some situations where I am permitted or required to disclose information without either your consent or authorization:

- If you are involved in a court proceeding and a request is made for information concerning my professional services, such information is protected by the therapist/patient privilege law. I cannot provide any information without your written authorization, or a court order. If you are involved in or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order me to disclose information.
- If a government agency is requesting the information for health oversight activities, I may be required to provide it for them.
- If a patient files a complaint or lawsuit against me, I may disclose relevant information regarding that patient in order to defend myself.
- If a patient files a worker's compensation claim, and I am providing treatment related to the claim, I must, upon appropriate request, furnish copies of all medical reports and bills.

There are some situations in which I am legally obligated to take actions, which I believe are necessary to attempt to protect others from harm and I may have to reveal some information about a patient's treatment. These situations are unusual in my practice.

- If I have reason to believe that a child has been abused, the law requires that I file a report with the appropriate governmental agency, usually the Department of Family and Children Services (DFCS). Once such a report is filed, I may be required to provide additional information.
- If I have reasonable cause to believe that a disabled adult or elder person has had a physical injury or injuries inflicted upon him or her, other than by accidental means, or that he or she has been neglected or exploited, I must report to an agency designated by the Department of Human Resources. Once I have filed such a report, I may be required to provide additional information.
- If I determine that a client presents a serious danger to him/herself or danger of violence to another, I may be required to take protective actions. These actions may include notifying the potential victim, and /or contacting the police, and/or seeking hospitalization for the patient.

If such a situation arises, I will make every effort to fully discuss it with you before taking any action and will limit my disclosure to what is necessary.

While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have now or in the future. The laws governing confidentiality can be quite complex, and I am not an attorney. In situations where specific advice is required, formal legal advice may be needed.

Professional Relationship

Psychotherapy is a professional service I will provide to you. Because of the nature of therapy, your relationship with me has to be different from most relationships. It may differ in how long it lasts, the objectives, or the topics discussed. It must also be limited to only the relationship of therapist and client. If you and I were to interact in any other ways, you would then have a "dual relationship," which could prove to be harmful to you in the long run and is, therefore, unethical in the mental health profession. Dual relationships can set up conflicts between my interests and your interests, and then the client's (your) interests might not be put first. In order to offer all of my clients the best care, my judgment needs to be unselfish and purely focused on your needs. This is why your relationship with me must remain professional in nature. Additionally, there are important differences between therapy and friendship. Friends may see your position only from their personal viewpoints and experiences. Friends may want to find quick and easy solutions to your problems so that they can feel helpful. These short-term solutions may not be in your long-term best interest. Friends do not usually follow up on their advice to see whether it was useful. They may *need* to have you do what they advise. A therapist offers you choices and helps you choose what is best for you. A therapist helps you learn how to solve problems better and make better decisions. A therapist's responses to your situation are based on tested theories and methods of change.
You should also know that by law and ethically I am required to keep the identity of my clients secret. As much as I may like to, for your confidentiality I will not address you in public unless you speak me first. I also must decline any invitation to attend gatherings with your family or friends. Lastly, when your therapy is completed, I will not be able to be a friend to you like your other friends. In addition, I will not accept friend requests from social networking sites such as Facebook, LinkedIn, MySpace, Tagged or any other such kind. I will only respond to emails that are in reference to your treatment. Please note that all email correspondence will become a part of your **clinical** record. In sum, it is the duty of your therapist to always maintain a professional role. Please note that these guidelines are not meant to be discourteous in any way, they are strictly for your long-term protection.

Professional Records

You should be aware that, pursuant to HIPAA, I keep Protected Health Information about you or your child in two sets of professional records. One set constitutes your Clinical Record. It includes information about: your reasons for seeking therapy, a description of the ways in which your or your child's problem impacts on your life, diagnosis, the goals that we set for treatment, progress towards those goals, medical and social history, treatment history, any past treatment records that I receive from other providers, reports of any professional consultations, billing records, and any reports that have been sent to anyone, including reports to your insurance carrier. Except in unusual circumstances that involve danger to yourself, your child, or others or makes reference to another person (unless such other person is a health care provider) and I believe that access is reasonably likely to cause substantial harm to such other person (or if information is supplied to me confidentially by others), you or your legal representative may examine and /or receive a copy of your or your child's Clinical Record, if you request it in writing. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. For this reason, I require that you initially review them in my presence, or have them forwarded to another mental health professional so you can discuss the contents. In most situations, I am allowed to charge a copying fee. The exceptions to this policy are contained in the attached Notice Form. If I refuse your request for access to your records, you have a right of review (except for information provided to me confidentially by others) which I will discuss with you upon request. In addition, I also keep a set of Psychotherapy Notes. These Notes are for my own use and are designed to assist me in providing you or your child with the best treatment. While the contents of Psychotherapy Notes vary from client to client, they can include the contents of our conversations, my analysis of those conversations, and how they impact on your or your child's therapy. They also contain particularly sensitive information that you or your child may reveal to me that is not required to be included in your Clinical Record and information supplied to me confidentially by others. These Psychotherapy Notes are kept separate from your Clinical Record. Your Psychotherapy Notes are not available to you. They also cannot be sent to anyone else, including insurance companies without your written, signed authorization. Insurance companies cannot require your authorization as a condition of coverage nor penalize you in any way for your refusal to provide it.

Patient Rights
HIPAA provides you with several new or expanded rights with regard to your Clinical Record and disclosures of protected health information. These rights include requesting that I amend your or your child's record; requesting restrictions on what information from your Clinical Record is disclosed to others; requesting an accounting of most disclosures of protected health information that you have neither consented to nor authorized; determining the location to which protected information disclosures are sent; having any complaints you make about my policies and procedures recorded in your records; and the right to a paper copy of this agreement; the attached notice form, and my privacy policies and procedures. I am happy to discuss any of these rights with you.

Minors & Parents
Clients under 18 years of age who are not emancipated, as well as their parents should be aware that the law allows parents to examine their child's treatment records unless I believe that doing so would endanger the child or we agree otherwise. Because privacy in psychotherapy is often crucial to successful progress, particularly with teenagers, it is typically my policy to request an agreement from parents that they consent to give up their access to their child's records. If they agree, during treatment, I will provide them only with general information about the progress of the child's treatment, and his/her attendance at scheduled sessions. I will also provide parents with a summary of their child's treatment when it is complete. Any other communication will require the child's authorization, unless I feel that the child is in danger or is a danger to someone else, in which case, I will notify the parents of my concern. Before giving parents any information, I will discuss the matter with the child, if possible, and do my best to handle any objections he/she may have.

Financial Arrangements

Professional Fees
I have a set of hourly fees (a session hour is 45-50 minutes). In addition to weekly appointments, I charge this amount for other professional services you or your child may need, though I will break down the hourly cost if I work for periods of less than one hour. Other services include report and letter writing, telephone or email conversations lasting longer than 10 minutes, consulting with other professionals with your permission, preparation of records or treatment summaries, and the time spent performing any other service you may request of me. **These services are not covered by your insurance company**. **No records (written or verbal) will be released to you or on your behalf if you have an outstanding balance due to NVCC.**
If you become involved in legal proceedings that require my participation, you will be expected to pay for all of my professional time, including preparation and transportation costs, even if I am called to testify by another party.
You will be charged the missed visit fee for any sessions missed or cancelled with less than 24 hours notice unless due to an emergency situation. You may leave a message on my voicemail on weekends or after hours to cancel an appointment or contact the scheduling department. **Appointments cannot be scheduled or cancelled via email as it is not a always a reliable, confidential source and not monitored 24/7**. **Please note that insurance companies do not pay for missed / cancelled appointments, so you will be responsible for the missed visit fee. There will be a $25 fee assessed for all returned checks. The card on file will be charged the original amount owed PLUS the $25 returned check fee.**

Billing and Payments
You will be expected to pay for each session at the time it is held, unless you have insurance coverage or we agree otherwise. If you have insurance, you are required to pay your co-pay/deductible at the time of service. Payment schedules for other professional services will be agreed to when they are requested. If your account has not been paid for more than 30 days and arrangements for payment have not been agreed upon, I have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court which will require me to disclose otherwise confidential information. In most collection situations, the only information I release regarding a patient's treatment is his/her name, the nature of services provided, and the amount due. If such legal action is necessary, its costs will be included in the claim.

Authorization for Recording

In order to conduct business in a quick and seamless fashion, we may have to contact you or your insurance company via the telephone. These conversations are recorded by our office and records are maintained and kept in the same manner as your Clinical Record. This ensures that our office has evidence if there is ever a dispute over a scheduled appointment, authorization of a credit card, or approval of insurance coverage. At no time will medical issues or therapy be discussed or recorded during a telephone call to our office.

Insurance Reimbursement

In order for us to set realistic goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. If you have a health insurance policy, it will usually provide some coverage for mental health treatment. I will fill out forms and provide you with assistance in helping you receive the benefits to which you are entitled; however you (not your insurance company) are responsible for full payment of my fees. **It is very important that you find out exactly what mental health benefits your insurance policy provides, such as co-pays, deductibles, maximum number of sessions allowed, etc.**

You should carefully read the section in your insurance coverage booklet that describes mental health services. If you have questions about the coverage, call your plan administrator. If it is necessary to clear confusion, I, or my staff, will be willing to call the company on your behalf. Many insurance plans such as HMOs and PPOs require authorization before they provide reimbursement for mental health services. **It is your responsibility to call your insurance company and obtain authorization before your first appointment. If authorization was required and is not obtained, your insurance will deny payment and you will be responsible for the hourly rate.** I will submit the appropriate bills to your insurance company one time and try to remedy any denial or payment problem related to billing one time. If after these billing attempts, the insurance company refuses to pay the bill, it will become your (the client's) responsibility to work with the insurance company to obtain appropriate reimbursement.

If you or your child is covered by a secondary insurance plan, I will be happy to provide you with appropriate billing forms and Explanation of Benefit (EOB) forms from your primary plan. I ask that you be responsible for payment of the portion of services not covered by your primary plan and that you seek reimbursement from the secondary plan for yourself. Typical insurance plans such as HMO's and PPO's are often limited to short-term treatment approaches designed to work out specific problems that interfere with a person's usual level of functioning. It may be necessary to seek approval for more therapy after a certain number of sessions. It will typically be my responsibility to obtain authorization for further sessions. While much can be accomplished in short-term therapy, some patients feel that they need more services after insurance benefits end. Some managed care plans will not allow me to provide services to you once your benefits end. If this is the case, I will do my best to plan to continue working with you or find another provider who will help you continue your psychotherapy. You should also be aware that your contract with your health insurance company requires that I provide it with information relevant to the services that I provide to you. I am required to provide a clinical diagnosis. Sometimes I am required to provide additional clinical information such as treatment plans or summaries, or copies of your entire Clinical Record. In such situations, I will make every effort to release only the minimum information about you that is necessary for the purpose requested. This information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, I have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank. I will provide you with a copy of any report I submit, if you request it. By signing this agreement, you agree that I can provide requested information to your insurance carrier. Once we have all of the information about your insurance coverage, we will discuss what we can expect to accomplish with the benefits that are available and what will happen if they run out before you feel ready to end your sessions. It is important to remember that you always have the right to pay for my services yourself to avoid the problems described above unless prohibited by contract.

Some Other Important Insurance Information

We have had circumstances where clients have questioned whether a visit can be "coded" as something other than what it may be (individual session, family session, couples session, etc). Not only is such action unethical, but it also constitutes insurance fraud, which is illegal. Just as we commit to our clients to be honest and forthright, so too are we honest and straightforward with the insurance companies.

Lastly, it is important that you know that your insurance companies have the right to review claims for proper

reimbursement for up to one year after the claim is made. This means that reimbursements that were made in the past for what was communicated by the insurance company as a covered diagnosis or service can be reversed. When this occurs, the insurance company can demand refund reimbursement from you or from New Vision Counseling Center, LLC depending on who was paid the benefit. Should an insurance company in the future deny benefits for services rendered in the past and thus request refund of payment to them, the payment for the services becomes the responsibility of the client. Insurance companies and NVCC can and will pursue reimbursement from clients and will use any and all means necessary to get these payments including legal action.

Please understand your plan - what it covers and what it does not. Make certain that all of your decisions in your treatment process are based on your full understanding of the nature and scope of the related clinical, psychological and financial elements.

Court Attendance, On-Call, and Communication with Attorneys/Other Professionals

New Vision Counseling Center, LLC bills at the rate of $200.00 per hour for court attendance and requires credit card information to be on file. The hourly rate begins when the therapist leaves the office location and a fee for two hours will be paid prior to court attendance, ($400.00) and is non-refundable if less time is needed. If the court attendance exceeds two hours, your credit card will be billed for the remaining time. Payment is for the therapist's time and not necessarily their testimony. Therefore, the fees are expected to be paid regardless of whether the therapist testifies or not. If you request for your therapist to be on-call for court attendance, New Vision Counseling Center, LLC bills at the rate of $60.00 per hour for on-call and requires credit card information to be on file for payment to be charged. The hours requested for the therapist to be on call will immediately be charged to your credit card on file and is non-refundable.

Communication with Attorneys/Other professionals/Report writing:

New Vision Counseling Center, LLC bills at the rate of $100.00 per hour for any type of communication with attorneys/other professionals/report writing (phone calls, letter writing, email, etc). You are responsible for providing credit card information prior to any communication your therapist will have with their attorney/other outside professional. A minimum of 30 minute increments will be billed to your credit card on file and is non-refundable. **Communication fees paid by check will require bank clearance before services will be rendered. After payment is received and processed, please allow up to 7 business days for paperwork/communication to be completed.**

Records Request

New Vision Counseling Center, LLC bills a flat rate of $25 for records to be copied and faxed/given to the client. If records need to be mailed, an additional fee of $10 is assessed to cover certified mail and postage. After payment is received and processed, please allow up to 7 business days for copies to be provided and/or mailed.

Agreement of Participation

I agree that I (or my child) will participate in outpatient counseling at New Vision Counseling Center, LLC (NVCC). In part of this agreement, I (or my child) make the commitment to be at NVCC at a mutually agreed upon day and time. I also understand that if I (or my child) am unable to attend counseling for any reason, I will need to give NVCC at least 24 hours notice. I am already aware that I will be responsible for paying the missed visit fee of any appointment not cancelled with a 24 hour notice. Lastly, I will acknowledge that if I (or my child) miss more than 2 appointments and/or do not give NVCC at least a 24 hour notice, that counseling services may be discontinued and that I will receive an appropriate referral. I also understand that NVCC will assist me in submitting claims to all insurance coverages I provide; however, the ultimate financial responsibility for services provided by NVCC is mine. Failure of insurance to pay a claim will not mitigate any claim NVCC may have for services provided to me (or my child). I further understand that if I continue to incur fees that are my responsibility for services rendered, NVCC has the right to and may terminate therapy and I will receive an appropriate referral.